CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00030/1

TITLE: MassHealth Demonstration

AWARDEE: Massachusetts Division of Medical Assistance (DMA)

NOTE: All special terms and conditions prefaced with an asterisk (*) contain requirements that must be approved by the Centers for Medicare & Medicaid Services (CMS) prior to marketing, enrollment, or implementation. No Federal Financial Participation (FFP) will be provided for marketing, enrollment, or implementation until CMS has approved these requirements. FFP will be available for project development and implementation, and for compliance with terms and conditions, the readiness review, etc. Unless otherwise specified where the Commonwealth is required to obtain CMS approval of a submission, CMS will make every effort to respond to the submission in writing within 30 days of receipt of the submission. All submissions for review and approval shall be made to the CMS project officer.

*1. The 1115 waivers necessary to implement the MassHealth demonstration will not be effective for the MassHealth demonstration until the Commonwealth has enacted enabling legislation. The Commonwealth shall not initiate marketing of individual plans for MassHealth before 90 days after the later of: (1) the date of the award letter, or (2) final CMS approval of any changes made as a consequence of enactment of Commonwealth enabling legislation.

2. a. All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the MassHealth program. To the extent the enforcement of such laws, regulations, and policy statements, in the absence of the MassHealth demonstration, would have affected Commonwealth spending on program components affected by the MassHealth demonstration in ways not explicitly anticipated in this agreement, CMS shall incorporate such effects into a modified budget limit for MassHealth. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. CMS will have 2 years after the determination of the budget neutrality base for MassHealth to notify the Commonwealth that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment A, are not subject to change under this special term and condition. If any portion of the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the MassHealth demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the Commonwealth's budget limit of that portion of the law shall be proportional to the size of the MassHealth demonstration in

comparison to its entire Medicaid program (as measured in aggregate Medical Assistance payments).

b. The Commonwealth shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the approval date of this waiver. To the extent that a change in Federal law that impacts statewide section 1115 demonstrations such as MassHealth would, in the absence of the waiver, affect State Medicaid spending on program components affected by the MassHealth demonstration, CMS shall incorporate such changes in law into a modified budget limit for MassHealth. The modified budget limit would be effective upon implementation of the change in the Federal law, as specified in law. If mandated changes in the federal law require state legislation, the change shall take effect on the day such state legislation becomes effective, or in the absence of such legislation, on the last day such legislation was required. If any portion of the new law cannot be linked specifically with program components that are or are not affected by the MassHealth demonstration (e.g., laws affecting sources of Medicaid funding), the effect of that portion of the new law on the Commonwealth's budget limit shall be proportional to the size of the MassHealth demonstration in comparison to its entire Medicaid program (as measured in aggregate Medical Assistance payments).

c. The Commonwealth may submit to CMS an amendment to the MassHealth program to request exemption from changes in law occurring after the approval date of this waiver. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under the modified MassHealth program do not exceed projected expenditures in the absence of MassHealth (assuming full compliance with the change in law).

d. Any modifications by the Commonwealth to the MassHealth program must be submitted in writing and are subject to prior approval by CMS.

*3. Within 60 days of the enactment of enabling Commonwealth legislation, the Commonwealth will submit a pre-implementation workplan for approval by CMS. The workplan will specify timeframes for major milestones and related subtasks for MassHealth managed care expansion.

*4. The Commonwealth shall prepare one protocol document that represents the policy and operating provisions applicable to this demonstration which have been agreed to by the Commonwealth and CMS. The protocol will include but not be limited to, a description of: marketing and recipient education strategies and methods; outreach programs; plan selection; enrollment process; the Commonwealth's procedures for implementation of fiscal management controls; and lock in policies for traditional eligibles in the Medicaid program and new eligibles under the demonstration who are required to enroll in managed care plans. The protocol must be submitted to CMS no later than 120 days prior to implementation. CMS will respond within 45 days of receipt of the protocol. During the demonstration, subsequent changes to the protocol should be submitted on an ongoing basis no later than 90 days prior to the date of implementation for approval by CMS. A number of Special Terms and Conditions include other information and requirements which also should be included in the

protocol. Attachment C is an outline of all the areas that must be covered in the protocol.

5. Upon enactment of enabling legislation authorizing the Commonwealth to implement MassHealth all managed care programs currently authorized under a 1915(b) waiver will be incorporated into and subsumed under the 1115(a) MassHealth waiver.

6. a. The Commonwealth will submit a phase-out plan of the demonstration to CMS at least 6 months prior to initiating phase-out activities and, if desired by the Commonwealth, an extension plan on a timely basis to prevent disenrollment of MassHealth members if the waiver is extended by CMS. Nothing herein shall be construed as preventing the Commonwealth from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval.

b. During the last 6 months of the demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current State plan will not be permitted unless the waiver is extended by CMS.

*7. The Commonwealth must describe in the protocol how Boston City Hospital and the Cambridge Hospital will participate in the demonstration. The Commonwealth shall contract with Boston City Hospital and Cambridge Hospital to provide services under the demonstration, unless these hospitals agree to provide these services under contract with other MassHealth managed care plans, or unless the Commonwealth demonstrates to the Department of Health and Human Services that Medicaid recipients and uninsured persons currently served by these hospitals will be adequately served by other MassHealth managed care plans.

Encounter Data

*8. The managed care plans (MCPs) shall be responsible for the collection of 100 percent encounter data and the maintenance of the data at the plan level. The Commonwealth shall, in addition, develop plans for the collection, reporting, and analysis of select encounter data from the Primary Care Clinician (PCC), HMO, and New State Benefit Plans, as well as a process for the validation of the systems used to collect such data, consistent with terms and conditions 9 and 10 below.

9. The Commonwealth shall collect and forward to CMS or its designated evaluator 100 percent encounter data on selected clinical indicators, to be reported annually to CMS within six months of the end of each calendar year reporting period. The Commonwealth shall include an analysis of the managed care plan performance, and when statistically appropriate, by individual prepaid health plan. Such analyses shall also incorporate the following measures and variables:

a. prenatal care

i. low birth weight/1000
ii. infant mortality rate
iii. post-partum one month follow-up rate

iv. percent of women starting care during the first trimester
v. ethnicity (Plans shall utilize ethnicity information on MassHealth enrollees as provided by the Commonwealth).

b. pediatric well care (immunizations)

i. immunization rate
(a) ethnicity (Plans shall utilize ethnicity information on MassHealth enrollees as provided by the Commonwealth).

c. pediatric asthma

i. bed days/1000
ii. emergency room visit rate

d. one additional clinical condition affecting persons with disabilities

The Commonwealth shall also report annually its assessment of the implications of the measurement data and plans to effect improvements where it deems such efforts to be appropriate.

10. The Commonwealth (or its contractor) shall conduct a study on the completeness and accuracy of encounter data collection of the MCPs with which it currently contracts. This study will determine the comprehensiveness and accuracy of encounter data collected for Medicaid enrollees in such plans. The study shall include the following tasks:

a. The Commonwealth shall determine the encounter data which are collected by its currently contracted managed care plans. A site visit will be made to each health plan to establish how encounter data are collected and processed by the plan. Interviews will be conducted with staff from Management Information Systems, Quality Assurance, and management. The Commonwealth will prepare a report that, for each health plan, identifies which of the elements of a minimum data set (MDS) to be defined by the Commonwealth (and to include at least inpatient and physician services) are being collected. The Commonwealth shall verify from plan reports that such data elements are collected. The Commonwealth will collect plan data dictionaries, if available, and assess their completeness. The Commonwealth will then analyze the consistency of encounter data collection across plans and establish a strategy for assuring consistency during the demonstration.

b. The Commonwealth will conduct annual validity studies to determine the completeness and accuracy of encounter data. For initial validation, the Commonwealth shall require each plan to pull the medical records of 50 MassHealth enrollees (chosen randomly by the Commonwealth) and provide a report from administrative data bases of the encounters of those enrollees. During subsequent annual validation studies, sufficient medical records should be audited to produce a statistically sound study, the design of which is subject

to CMS approval. The Commonwealth shall compare the utilization data from the medical record and from the administrative databases report using the data elements contained in the Commonwealth's CMS approved Minimum Data Set (MDS). If the plan's encounter data are both complete and accurate for 90 percent or more of the data elements contained in the CMS MDS, that plan's encounter data system will be considered acceptable. If the completeness and/or accuracy are less than 90 percent, the Commonwealth shall require the plan to implement a corrective action plan within 90 days to bring the accuracy to the acceptable level. The Commonwealth shall conduct a validity study following the end of a twelve month period after the implementation of the corrective action plan to assess whether the plan has attained 90 percent completeness. Plans that fail to achieve a 90 percent accuracy level following completion of the corrective action plan shall not be permitted to participate in the demonstration. After the first 2 operational years, CMS will re-evaluate the need for annual audits with DMA for those plans which have met the threshold for acceptability in both years.

11. If the Commonwealth contracts with new plans, prior to the effective date of the contract the Commonwealth will do a validation study on the completeness and accuracy of encounter data. If the plan is a newly established MCP, the Commonwealth will do a validation study six months after the effective date of the contract. The validity study, and accuracy standards are as required under term and condition #10b.

12. The Commonwealth shall assure access to utilization data for employees receiving subsidies under the Insurance Reimbursement Program (IRP). Such data shall be collected through routine survey of IRP enrollees receiving subsidies from the Commonwealth.

13. The Commonwealth must assure that encounter data maintained at MCPs can be linked with eligibility files maintained at the Commonwealth.

Quality Assurance

*14. In the protocol, the Commonwealth must provide its overall quality assurance monitoring plan for each component of MassHealth, which shall include the monitoring of mental health and substance abuse treatment.

*15. a. Within 12 months of implementation, the Commonwealth will conduct a statistically valid sample survey of enrollees in each contracted prepaid health plan and the PCC Plan. The survey, which shall be described in the protocol, will measure satisfaction with services provided and access to primary care, mental health, and special services. Results of the survey must be provided to CMS by the eighteenth month of waiver implementation. Thereafter, the Commonwealth will conduct beneficiary surveys during each year of the demonstration as part of its quality improvement and performance monitoring process.

b. The Commonwealth will establish a quality improvement process for bringing contracted managed care plans, which score below 70 percent in overall beneficiary satisfaction, up to an acceptable performance level.

16. Massachusetts will annually collect and report summary data to CMS on grievances received and the corrective action taken by each contracted prepaid health plan. The Commonwealth will identify plans it considers to be grievance outliers and identify what monitoring and corrective action will be taken.

*17. The Commonwealth must develop internal and external audits to monitor the performance of the plans under MassHealth. At a minimum, the Commonwealth shall monitor the financial performance and quality assurance activities of each contracted prepaid health plan. The detailed criteria for the monitoring must be provided in the protocol. The Commonwealth will submit to the Office of Research and Demonstrations (ORD) and the CMS Regional Office copies of all financial audits of participating MCPs and quality assessment reviews of these plans.

18. The Commonwealth shall meet all applicable Federal periodic medical audit requirements for contracted managed care plans participating in the MassHealth program, and the contracted plans shall satisfy access and solvency standards established by CMS pursuant to 1903(m)(1)(A), and shall meet requirements in 1902(w).

Eligibility/Benefits

*19. As part of the protocol document, the following plans will be provided to CMS 120 days prior to implementation.

a. a plan which describes the centralized and simplified eligibility determination process and which will include:

i. a complete description of all MassHealth eligibles,

ii. a sample of the revised application and any applicable attachments used in determining eligibility for the Insurance Reimbursement Plan (IRP),

iii. a description of the role and placement of outstationed workers,

iv. a description of how the eligibility determination process is coordinated with the enrollment process conducted by Health Benefit Managers, and how the eligibility determination process (including persons whose eligibility is determined by the Massachusetts Commission for the Blind) for the DMA-administered plans is coordinated with the eligibility determination and enrollment process for the Department of Medical Security-administered Medical Security Plan (MSP).

v. A description of how eligibility verification procedures will be modified under the waiver.

b. a plan for ending the spenddown portion of the Medically Needy Program (which is described at 42 CFR 435.301(a)(1)(ii)), which includes a description of the process for identifying the unemployed disabled persons in the Medically Needy category of assistance and for transitioning them out of Medicaid and enrolling them into the expanded CommonHealth program;

c. a plan for monitoring the number of people who lose eligibility and become ineligible for any MassHealth program; and,

d. a plan for ensuring that people who lose Medicaid due to the elimination of the spenddown portion of the Medically Needy program or any of the other changes in Medicaid eligibility rules but who become eligible for one of the new programs under MassHealth are referred for enrollment into one of those programs.

e. the plan for terminating the Commonwealth's Children's Medical Security Plan (administered by the Department of Medical Security) and enrolling all MassHealth eligible children into MassHealth programs. The plan shall include:

i. a description of the process which will be used to track the number of children who are ineligible for MassHealth programs, and

ii. a description of the process for ensuring that the parent or guardian of children who are eligible for MassHealth programs are referred to Health Benefits Managers who can assist them with their enrollment decisions.

f. a plan describing the process that will be implemented to identify and certify those insurance plans which meet the basic benefit level of coverage in order to be eligible for tax credits.

g. The protocol shall include a description of a plan which will ensure that the change in retroactive eligibility from prior quarter to date of application does not impede recipient access to benefits. The description shall include:

- how the Division will work with hospitals (and assist prospective recipients) to ensure the submission of timely, complete and qualified applications, and

- how the Division shall ensure timely review and approval of qualified applications.

*20. As part of the protocol document, the Commonwealth will describe how those non-disabled recipients who would lose current Medicaid eligibility coverage due to the elimination of the spenddown portion of the Medically Needy Program will be grandfathered into the MassHealth demonstration.

*21. The Commonwealth shall submit, within 120 days of enactment of Commonwealth enabling legislation, a description of the eligibility determination post-audit review procedure which will replace the standard Medicaid eligibility quality control sample. Beginning 6 months after the implementation of the demonstration, every 6 months the Commonwealth will complete a sample of an appropriate number of cases, based on enrollment and approved by CMS, from MassHealth enrollees. This new procedure shall be used for all Medicaid coverage groups, including those receiving services under the waiver and those not receiving services under the waiver (the 65 and over population as well as those who are under 65 and institutionalized). Findings will be reviewed on a semi-annual basis.

The procedure shall ensure that all Medicaid recipients meet applicable eligibility requirements and that there is adequate monitoring of the administration of eligibility determination processes under MassHealth. The procedure must include a process to verify individuals' eligibility for a subsidy under the Insurance Reimbursement Program. This would include verifying the individual's income and the calculation used to determine the amount of the subsidy. Also, the Commonwealth must verify that the employee is purchasing health insurance, that the health insurance meets the basic benefit level, as defined by the Commonwealth, and that the employer is contributing at least 50 percent towards the cost of the premium. The self-employed are eligible for tax credits and subsidies, providing the requirements of the IRP are complied with (health insurance benefits must, at least, meet the basic benefit level.)

The Commonwealth shall establish internal controls to determine the validity of the eligibility determination post-audit review procedure.

Enrollment

*22. As part of the protocol document, information on enrollment into MassHealth must be provided to CMS 120 days prior to implementation. The following information must be included:

a. Regarding the Health Benefits Manager-assisted enrollment, the Commonwealth will provide:

i. a description of the processes Health Benefits Managers (HBMs) will use to provide recipients with the information they need to select the plan or the primary care clinician provider which is best for them. This will include:

(1) The process by which HBMs will inform IRP-eligibles about the subsidy amount for which they are eligible and how to access it, and about the health insurance options available to them through the marketplace and through the DMA.

(2) The process by which HBMs will determine eligibility for and enroll clients in the three MassHealth programs for which they manage enrollment: the Managed Care Program, the New State Benefit Program (NSBP) and the IRP.

(3) The process by which participating managed care plans will be informed of new or departing enrollments.

i. a description of how recipients of Emergency Aid to Elderly, Disabled, and Children-Health will be identified, educated about their options, and enrolled into NSBP.

iii. a description of how HBMs can be reached.

b. Regarding assignment to a managed care provider, the Commonwealth will provide:

i. a description of how enrollment by participating HMO, prepaid health plan (PHP), or Primary Care Clinician (PCC) will be tracked and recorded.

ii. a description of how the Commonwealth will monitor rates of assignment to managed care providers under MassHealth.

c. Regarding assignment into the HMO Program:

i. a description of how and when applicants, who have gone through the eligibility determination process and have been determined eligible for the Managed Care Program but who have not yet selected a PCC or HMO, shall be assigned to either an HMO or a PCC.

d. Regarding assignment into plans participating in the New State Benefit Plan:

i. a description of how and when applicants, who have gone through the eligibility determination process and have been determined eligible for the NSBP but who have not yet selected a managed care plan, shall be assigned.

e. Regarding the assignment process, the Commonwealth shall develop and submit standards for rates of automatic versus voluntary enrollments, for the purpose of continual improvement.

*23. The Commonwealth will also submit as part of the protocol, a procedure for folding persons whose eligibility is determined by the Massachusetts Commission for the Blind (MCB) into MassHealth. The protocol will address eligibility determinations and financial reporting.

*24. As part of the protocol, the Commonwealth will submit a plan for managing beneficiary enrollments and the marketing process. The plan shall describe the following:

a. Procedures for monitoring Health Benefit Manager (HBM) performance.

b. Allowable marketing strategies and methods.

c. The training curriculum for eligibility and outstationed workers employed by the Division of Medical Assistance, who determine eligibility for all programs under MassHealth, with the exception of the Medical Security Plan (MSP).

d. The training curriculum for eligibility workers employed by the Department of Medical Security which administers the Medical Security Plan (MSP).

*25. As part of the protocol the Commonwealth shall submit the following to CMS regarding the training of HBMs in MassHealth:

a. a description of the training process for HBMs which shall include a description of the process for providing staff with ongoing training consisting of timely updates on the latest changes in program policy, and information on selected topics, and addressing, at a minimum, remedial training, refresher training and a process for disseminating new information;

b. a plan for implementing the training process;

c. a description of the contents of the training curriculum for HBMs which shall include:

i. Non-biased enrollment training, including codes of conduct.

ii. Instruction for HBM staff on the following: 1) Each of the MassHealth managed care options which includes each HMO Plan as well as the PCC Plan and the Mental Health and Substance Abuse Program; and 2) Managed care plan options available under the New State Benefit Plan.

iii. Education about health insurance coverage available in the marketplace, and how to activate a subsidy for recipients who are eligible for the subsidy under the Insurance Reimbursement Program (IRP), and the names and contact people at all other health care purchasing groups open to non-group members.

iv. How to coordinate the enrollment and eligibility determination processes with the Division's eligibility workers, as well as other state agencies' eligibility determination and enrollment staff.

v. How to make referrals to, and work with, the Department of Medical Security staff responsible for enrollment into the Medical Security Plan.

vi. How to utilize the Division's computer systems and electronic processes for effecting enrollments.

vii. A description of the CommonHealth Plan.

viii. A description of the Medical Security Plan's eligibility rules and benefits.

ix. Information on managed care plan enrollee rights and responsibilities.

Federal Financial Participation/Cost Control/Fiscal Administration

*26. a. The Commonwealth shall provide quarterly expenditure reports using the form HCFA 64 to separately report expenditures for those receiving services under the Medicaid program and those participating in MassHealth under section 1115 authority. CMS will provide FFP only for allowable MassHealth expenditures that do not exceed the pre-defined limits as specified in Attachment A.

b. In order to track expenditures under this demonstration, Massachusetts must submit a complete form HCFA 64 according to standard Medicaid reporting requirements through the MBES that clearly differentiates between program expenditures made under the authority in CMS's approval of the MassHealth demonstration and expenditures which are made under ordinary Medicaid rules not affected by the waiver, on a quarterly basis according to standard Medicaid reporting requirements. In addition, quarterly supplemental schedules that reconcile to the reported HCFA 64 MassHealth amounts must be concurrently submitted that detail MassHealth services. A separate accounting of Disproportionate Share Hospital (DSH) payments and benefit costs must be provided to facilitate fiscal oversight. The cash payments (current and prior period) reported for MassHealth on the HCFA 64 must be by service date year and must separately identify all capitated and non-capitated payments for each Commonwealth agency. The procedures related to this reporting process must be approved by CMS as part of the protocol referenced in term and condition #4. Administrative costs for the waiver need not be separated from non-waiver administrative costs.

c. In addition to the form HCFA 64, the Commonwealth shall provide to CMS on an annual basis (related to the period for which the expenditure limit is established) the actual caseloads for each of the MassHealth programs, and by appropriate groups within each of the programs. This caseload information should be provided to CMS 180 days after the end of the year.

d. For a period of two years after the termination of the waiver, the Commonwealth must continue to separately identify net expenditures related to dates of service during the operation of the 1115 waiver on the modified form HCFA 64 in order to properly account for these expenditures in determining budget neutrality.

27. The standard Medicaid funding process will be used during the demonstration. MassHealth must estimate matchable Massachusetts Medicaid expenditures on the quarterly form HCFA-37. The Commonwealth must provide supplemental schedules that clearly distinguish between at-risk MassHealth estimates (by major component) and Massachusetts Medicaid estimates that are not at-risk. CMS will make Federal funds available each quarter based upon the Commonwealth's estimates, as approved

by CMS. Within 30 days after the end of each quarter, the Commonwealth must submit the form HCFA 64 quarterly Medicaid expenditure report, showing Medicaid and MassHealth expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form HCFA 64 with Federal funding previously made available to the Commonwealth for that quarter, and include the reconciling adjustment in a separate grant award to the Commonwealth.

28. The Commonwealth shall ensure that all costs claimed for Federal financial participation under the demonstration are not already being reimbursed through existing statewide or department cost allocation plans. Such costs as overhead and administration for new programs and state staff may not duplicate costs already being charged to the Medicaid Program.

29. CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment A:

    a. Administrative costs associated with the direct administration of MassHealth at the appropriate FFP rate authorized under Medicaid.

    b. Net expenditures and prior period adjustments of the Medicaid and MassHealth programs which are paid in accordance with the approved State plan. CMS will provide FFP for medical assistance payments with dates of service prior to and during the operation of the 1115 waiver.

    c. Expenditures incurred under performance-based contracts with non-comprehensive prepaid health plans providing services under the NSBP, and Primary Care Clinicians.

    d. At the enhanced Federal match rate (75%), for costs related to the performance of annual independent, external reviews of the quality of services furnished by Health Maintenance Organizations conducted by organizations which are determined by CMS to meet the definition of a utilization and quality control peer review organization (PRO) contained in section 1152 of the Social Security Act. The entity must be either a physician-sponsored organization or a physician-access organization, and must demonstrate the ability to perform required review functions as described in 42 CFR 462.101 -- 42 CFR 462.104. Additionally, the organization's governing body must have at least one individual who is a representative of consumers. Enhanced FFP may be claimed subject to CMS's determination that the organization does or does not meet the above criteria.

    e. Payments the Commonwealth makes directly to Institutions for Mental Disease (IMDs), both public and private, for IMD services provided to 1115-eligible individuals aged 21 through 64 for inpatient admissions during the demonstration with inpatient stays of up to 30 consecutive days per episode and for up to 60 inpatient days for each eligible individual per year; provided however, that such limitation on the scope of such direct IMD payments shall not apply to or be construed to limit the scope of IMD services provided by any HMO or PHP to its 1115 eligible enrollees where the capitated payments made by the Commonwealth to such HMO or PHP conforms with the Upper

Payment Limit (UPL) applicable to risk-based, capitated, prepaid health plans under 42 CFR Part 434; i.e., provided no Fee For Service (FFS) costs for such IMD services were included in the FFS benchmark used for calculating the UPL for such capitated rates under 42 CFR part 434.

f. Actual expenditures certified and incurred by acute care public hospitals for MassHealth enrollees, only to the extent that the public hospital is able to document that it has an actual unreimbursed expenditure for providing MassHealth services to a MassHealth enrollee which exceeds the amount paid to that provider by the Commonwealth of Massachusetts under MassHealth, by the MassHealth enrollee, by disproportionate share hospital payments, or by other non-public sources for the cost of providing such services to that MassHealth enrollee (as measured by the cost report filed with the Massachusetts Rate Setting Commission (RSC), or through the hospital's audited Medicare cost report).

g. The entire employee subsidy portion of the IRP, provided that the employer or self-employed person contributes at least 50 percent of the cost of health insurance benefits, which must meet the basic benefit level, as defined by the Commonwealth, and that the gross income of the employee's family is no more than 200% of FPL.

h. The employer (or self-employed) tax credit portion of the IRP for the amount of tax credit granted for "new employer-provided health insurance". "New employer-provided health insurance" is defined as 1) contributions of at least 50 percent of the cost of health insurance by employers who have made no contribution to the cost of employees' insurance during any part of the 12 months previous to the implementation of IRP, and 2) contributions of at least 50 percent of the cost of health insurance made to a class of employees by any employers who, during the 12 months previous to implementation of the IRP, had made no contribution to the health insurance for those employees currently in that class (where definition of class of employees, such as part-time employees, is subject to CMS approval, and where such class has contained employees during the 12 months previous to the implementation of the IRP). CMS will not match tax credits paid by the Commonwealth except as provided above, or as indicated in term and condition 31.

i. All DSH payments up to the annual DSH cap, and as permitted by the aggregate expenditure cap (as specified in Attachment A), to a hospital for unreimbursed patient care costs, as defined in accordance with 1923(g)(1)(A), for which there has been State financial participation consistent with the requirements of 42 CFR 433 Subpart B.

*30. As part of the protocol, the Commonwealth will submit a detailed and specific description of the documentation and audit trails for items, which are referenced in term and condition #29, for which FFP is provided.

31. "Continuing employer-provided health insurance" is defined as a contribution of at least 50 percent of the cost of health insurance by employers who have made the same contribution during the twelve months prior to the implementation of the IRP, toward

health insurance which met and meets the basic benefit level (BBL). This also applies to the self-employed period. Tax credits for continuing employer-provided health insurance will be State-financed, except as provided in term and condition 32.

"Improved employer-provided health insurance" is defined as 1) contributions of at least 50 percent of the cost of health insurance by employers who have made a contribution of less than 50 percent during any part of the 12 months previous to the implementation of IRP, and 2) contributions of at least 50% of the cost of health insurance made by employers who, had offered health insurance which did not meet the BBL. Tax credits for improved employer-provided health insurance will be State-financed, except as provided in term and condition 32.

Health insurance (individual, two-person, or family) purchased by a self-employed person on his/her own behalf, will be treated as employer-provided insurance, and will be eligible for tax credits and subsidies which, for FFP purposes, will be subject to the same definitions as above. For the purpose of making these determinations, one-half of the cost of health insurance purchased by the self-employed will be eligible for a tax credit and one-half will be eligible for an employee subsidy.

*32. After the second year of the demonstration, CMS will consider extending FFP to tax credits for employers which participated in the Commonwealth's provision of state-financed tax credits for continuing employer-provided health insurance and for improved employer-provided health insurance. To support a continuation or expansion of the IRP, the Commonwealth will submit a report to CMS on the results of employer surveys described in term and condition 33. From this report and other considerations, such as budget neutrality and comparisons of Massachusetts' experience with regional and national trends, CMS will make a determination within 90 days of receiving the report.

*33. As part of the protocol document the Commonwealth will include plans for data collection and employer surveys for collecting baseline and follow-up information on employer provided health insurance coverage, and the survey sampling methodology. The surveys will collect information on the extent of employer-provided health insurance in the Commonwealth at a point two years prior to the implementation date of the IRP (historic), as of the implementation date of the IRP (current), and during the second year of the demonstration. At a minimum the information collection shall include the status of and changes in employer provided health insurance coverage, including changes in percent of work force covered by level of coverage (single, two person, and three or more persons), basic benefit level (BBL) status or comprehensiveness of coverage, the amount of the premium paid by employer, total cost of health insurance premium, employer participation in healthcare purchaser groups, employer participation in community rating for small employers, number of employees, and the age of the firm. Data collection will include items related to firm size, such as firm revenue and profits. The Commonwealth may employ an independent contractor to conduct the impact study and surveys.

34. The annual financial statements of public hospitals, which incur certified public expenditures (CPE) eligible for FFP, shall be reviewed annually, and the results made available to CMS. Audit documentation should indicate the amount and designation of State and local appropriations provided to the hospital, specifying amounts

designated to cover costs eligible for FFP as unreimbursed CPE. Audit documentation should include the methodologies employed by hospitals to identify patient insurance status, enrollment in MassHealth, and the cost of services provided.

35. In order to claim the MassHealth match for an employer tax credit, the Commonwealth must show that the employer met all requirements to receive a federally matchable tax credit. Specifically, CMS must have authority to verify such data, based upon tax documentation described below, as the salary of the employee who is covered, the level of coverage taken (single, two person, and three or more persons), whether the employer contributes at least 50 percent of the cost of the premium, whether coverage is obtained, whether the employee's coverage qualifies as "new employer-provided health insurance", and whether the health insurance package meets the basic level, as defined by the Commonwealth. Appropriate tax documentation for all MassHealth matchable tax credits must be accessible, at the offices of the appropriate Commonwealth agencies, for review and audit by CMS or its designated agent. The Commonwealth must seek legislation to allow CMS or its designated agent to inspect tax records at the offices of appropriate Commonwealth agencies for the specific purpose of substantiating Medicaid expenditures.

36. The Commonwealth will make available for review all records that were used in the preparation and submission of the HCFA 64 and HCFA 37 reports.

*37. In the protocol the Commonwealth must submit a detailed description of both the free care pool and the reserve mechanism. The Commonwealth must detail the source of each pool's funds, how payment amounts will be determined, how bills will be paid, and what audit trail will exist. CMS will not match payments from the "reserve pool" mechanism until it approves the payment methodologies and documentation requirements for such mechanisms.

*38. At least 120 days prior to implementation, as part of the protocol document, the Commonwealth shall submit for CMS review and approval a report which will define counting conventions for estimating the number of persons who would have been eligible for Medicaid without the waiver and the number who are eligible under the demonstration. The approved conventions will be used during the demonstration.

*39. As part of the protocol, and subject to approval, the Commonwealth will provide CMS with its methodology for implementing and making payments to PCCs under performance-based contracts. The methodology shall include a plan(s) to pay FQHC(s) on either a full or partially capitated (risk) basis (with appropriate adjustments for case-mix) or on a cost-related basis. If during the demonstration the FQHC payment methodology changes, the changes must be submitted by the Commonwealth to CMS for review and approval.

Family Planning

*40. As part of the protocol document the Commonwealth must describe how confidentiality and unrestricted access to family planning services will be guaranteed to recipients eligible for MassHealth under streamlined eligibility.

Providers and Delivery Systems

41. The Commonwealth will use a Request for Proposal (RFP) process to select contracting managed care plans. This process will be open to all plans that meet MassHealth participation standards, including minority-owned plans. Before issuing the solicitation for managed care plans for services under MassHealth, the Commonwealth shall submit the RFP for review and allow 30 days for CMS to provide comments.

42. The Commonwealth will submit to CMS for approval all capitation rates, and the fee-for-service upper payment limits from which they are derived, for the MCPs throughout the demonstration. Also, the Commonwealth will submit the methodology for determining the fee-for-service upper payment limits for health plan services.

43. For the Medical Security Plan, New State Benefit Plan, CommonHealth, and Insurance Reimbursement Program, which serve or provide payments for persons eligible under the waiver as part of the expanded population, the State does not have to comply with Federal coverage and reimbursement requirements for rural health centers and federally qualified health centers.

*44. a. Model contracts between the Commonwealth and MCPs will be provided to CMS for approval prior to the start date of the delivery of services and prior to the completion of final contracts. The Commonwealth will provide CMS with 30 days to approve the model contract.

b. Final contracts between the Commonwealth and MCPs must be approved by CMS prior to the start date of the delivery of services.

c. The Commonwealth will provide CMS with 30 days to review and approve or disapprove the final contract prior to its effective date. Once these contracts are approved by CMS, FFP will be available from the effective date of such contracts, provided that the Commonwealth makes any modification to such contracts required as a condition of CMS's approval.

d. Before beginning marketing and enrollment, the Commonwealth must demonstrate to CMS under MassHealth that sufficient culturally competent access and capacity are available to potential enrollees. At a minimum, the Commonwealth shall meet the access requirements detailed in Attachment B. The Commonwealth will provide CMS with 30 days to review and approve such a demonstration.

e. In the protocol, the Commonwealth shall submit to CMS its contingency plans for assuring continued access to care for enrollees in the case of a MCP contract termination and/or insolvency.

f. CMS reserves the right to review and approve individual subcontracts between managed care plans and their providers in accordance with the same requirements as those imposed by these Special Terms and Conditions on

MCPs. Copies of subcontracts or individual provider agreements with managed care organizations shall be provided to CMS upon request.

g. In the protocol, the Commonwealth will describe its mechanism for reviewing all marketing materials used to promote enrollment in MCPs. The Commonwealth will not begin disseminating such materials until the marketing part of the protocol is approved by CMS.

45. Procurement and the subsequent final contracts developed to implement selective contracting, by the Commonwealth, with any provider group shall be subject to CMS Regional Office approval prior to implementation. The Commonwealth will provide CMS with 30 days to review and approve such a demonstration.

*46. The Commonwealth must meet the usual Medicaid disclosure requirements at 42 CFR Part 455, Subpart B, for contracting with MCPs prior to the start date of the demonstration. Such requirements include disclosure of ownership and completion of the standard CMS disclosure form.

*47. In the protocol, the Commonwealth will provide written policies on how mental health and substance abuse services will be coordinated for enrolled individuals who are eligible to receive these services from multiple Commonwealth agencies, such as the Division of Youth Services, the Department of Mental Health, and the Department of Social Services. Such policies must clearly delineate how and by whom such services will be provided, managed, and funded.

*48. In the protocol, the Commonwealth will submit a plan for monitoring the MassHealth Substance Abuse Program contractor's administration of "diversionary services." Such services include:

- acute residential treatment programs for substance abuse;
- acute residential treatment programs for children and adolescents (mental health);
- structured outpatient addiction programs;
- partial hospitalizations;
- family stabilization team services;
- community support programs in terms of clinical appropriateness and effectiveness.

*49. In the protocol, the Commonwealth shall submit a plan that describes how MassHealth providers will coordinate with providers of school-based services. The coordination plan must ensure continuity of care, and that no services, equipment or payments are duplicated. The plan must address:

a. how school health clinics which provide medical services to MassHealth eligibles coordinate with or assume the function of primary care providers,

and

b. how medical services delivered as part of special education are coordinated with the child's primary care provider.

The coordination plan must build linkages between managed care providers and school-based providers to ensure continuity of care, and that no services, equipment or payments are duplicated.

*50. In the protocol, the Commonwealth must describe its plans for redefining geographic service areas under the PCC program. The new policy should define a beneficiary's service area as an established list of cities/towns within a geographic area from which a managed care provider may be chosen, taking into consideration access for disabled recipients and prevailing commuting patterns to health care providers in the area.

The Commonwealth shall describe how beneficiaries will be informed of their right to request a PCC not located in the beneficiary's geographic area. Beneficiaries will be instructed that such request must be in writing to the Division of Medical Assistance (DMA) and must include the reason why an out-of-area enrollment should be granted. If the clinical benefit of receiving care from an in-area PCC is substantially outweighed by the clinical benefit of receiving care from an out-of-area PCC, then the out-of-area PCC will be approved by DMA. If approved, the beneficiary may be enrolled with the out-of-area provider. If the request is denied, the beneficiary is given the right to appeal this decision. In addition, if it is determined that there is no MassHealth-approved PCC or HMO available in the beneficiary's area, the beneficiary shall not be required to participate as long as such circumstances prevail.

*51. As part of the protocol, or as an amendment to the protocol prior to implementation of selective contracting, which CMS shall review and approve, the Commonwealth shall submit a plan for what access will be to federally qualified health centers under competitive bidding in Managed Care, and under performance-based contracting in the Primary Care Clinician Plan.

52. The Commonwealth shall publish adequate and timely notice under the Commonwealth's administrative procedure law of any program-wide changes made by the Commonwealth in the MassHealth benefit package, eligibility standards, procedures for obtaining care, or rights under the program. Whenever such program-wide changes are applied to an individual beneficiary or any action or intended action affecting an individual beneficiary is taken by the Commonwealth under existing program rules, the Commonwealth shall give individual, adequate, and timely notice to such beneficiary.

53. The Commonwealth will develop risk bands to apply to capitation rates for the New State Benefit Plan during the first 2 years of its operation. Such risk bands shall be developed without regard to an Upper Payment Limit for these 2 years. Under the risk band methodology, the Commonwealth (and Federal government) and its contracting managed care plans will share savings or losses under a distribution of risk formula (e.g. 60 percent Commonwealth, 40 percent managed care plan of savings or losses). The exact distribution of risk shall be determined by the

Commonwealth with participation by its contracted managed care plans, and with review by the Commonwealth's qualified actuary.

Administration/Reporting/Other

54. By April 1 of each year, the Commonwealth will submit Form HCFA-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the Commonwealth Medicaid Manual, with data for each line item arrayed by age group and basis of eligibility. Copies should be submitted simultaneously to CMS's Regional Office and to the CMS Central Office address contained in section 2700.4 of the Commonwealth Medicaid Manual. All data reported must be supported by documentation consistent with the general requirements of these terms and conditions.

55. All contracts and subcontracts for services related to MassHealth must provide that the Commonwealth agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed and (2) inspect and audit any financial records of such contractor/subcontractors.

56. For the first award year, and through the first 6 months of the operational year, (where the award year shall be defined as the 365-day-period beginning with the date of award and the operational year shall be defined as the 365-day-period beginning with the date of implementation), the Commonwealth will submit monthly progress reports to the CMS project officer. The monthly progress reports shall be due 20 days after the end of each calendar month.

    a. Prior to implementation the monthly progress reports shall consist of: updates, including additions or deletions to an initial workplan (the initial workplan will outline major milestones and subtasks by program component) as well as a brief summary of any substantial implementation issues and the Commonwealth's recommendation regarding those issues.

    b. Monthly post-implementation progress reports shall include enrollment tallies by program component as well as any relevant report information defined below in term and condition #56c.

    c. After the first six months of implementation, progress reports shall be submitted on a quarterly basis 60 days following the close of each quarter. Quarterly reports shall include a discussion of events occurring during the quarter that affect health care delivery, enrollment and outreach, quality of care (including statistics on grievances), access, health plan financial performance, the benefit package, and other operational issues. The report should also include proposals for addressing any problems identified. While reports based on clinical indicators will be reported annually in Encounter Data Reports, the quarterly reports should include utilization data and discussion of events and efforts related to the collection and verification of clinical encounter data.

57. The Commonwealth will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from ORD, a final annual report will be submitted.

*58. Massachusetts must implement procedures so that hospitals will be able to distinguish between 1) individuals eligible for MassHealth through streamlined eligibility, and individuals eligible for Medicaid who are not eligible for MassHealth; and 2) and all other MassHealth eligibles. These procedures must be in place and operational on the implementation date of the waiver so that hospitals can calculate Medicaid days throughout the life of the waiver. Correct accounting for Medicaid days is required for calculating a hospital's Medicare disproportionate share hospital (DSH) payments. Medicaid days for this purpose will be based on the individuals eligible according to #1 above. The proposed procedure must be submitted to CMS in the protocol.

59. Massachusetts will request modifications to the demonstration by submitting revisions to the protocol (special term and condition #4) for CMS approval. The Commonwealth shall not submit State plan amendments relating to the new programs of expanded eligibility.

*60. Prior to enrollment of beneficiaries into the new MassHealth programs, the Commonwealth must submit evidence to CMS that a management information system is in place which meets the minimum standards of performance or the functional equivalent required of the Commonwealth's current management information system.

61. At the end of the demonstration, a draft final report should be submitted to CMS for comments. CMS's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the CMS, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

62. CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines, following a hearing, that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The Commonwealth waives none of its rights to challenge CMS's finding that the Commonwealth materially failed to comply. CMS reserves the right to withdraw waivers at any time it determines that continuing the waiver would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal close-out costs.

63. CMS will contract with an independent contractor to evaluate the demonstration. The Commonwealth agrees to cooperate with the evaluator by responding in a timely manner to requests for interviews, access to records, and sharing of data. The Commonwealth has the right to review reports prepared by the evaluator. Data sharing is specified in other terms and conditions. The Commonwealth must make available at no cost to the CMS evaluation contractor, their eligibility files. The evaluation contractor shall be bound to CMS's regulations on rules of confidentiality.

64. Any letters, documents or other material sent to the project officer should also be sent to the Regional Office.

*65. A continuation application must be submitted 90 days prior to each "award year". The continuation application shall include a discussion of the major milestones and subtasks the Commonwealth plans to undertake as well as any modifications to the protocol the Commonwealth anticipates it will be proposing. In addition, the Commonwealth shall state continued commitment to the special terms and conditions of the award. Discussion of the accomplishments and issues encountered in the completed award year may be included in the continuation application by reference to proceeding deliverables.

Attachment A

Monitoring Budget Neutrality for the MassHealth Demonstration

The following describes the method by which budget neutrality will be assured under the MassHealth demonstration. In general, Massachusetts will be using a per capita cost method, and demonstration budget targets will be set on a yearly basis, with a cumulative 8-year budget limit. Massachusetts will be at risk for the per capita cost (as determined by the method described below) for current eligibles, but not at risk for the number of current eligibles. By providing Federal Financial Participation for all current eligibles (including 1902(r)(2) eligibles), Massachusetts will not be at risk for changing economic conditions. However, by placing Massachusetts at risk for the per capita costs for current eligibles, CMS assures that the demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

Each yearly expenditure target for MassHealth will be the sum of two budget components: (A) the projected costs of the benefit services by specified categories of assistance (COA); and (B) the projected Disproportionate Share Hospital (DSH) expenditures. Each of these components has a distinct method for projecting costs into the future. Benefit service projections for the first five years will be for Families, Disabled, Massachusetts Commission for the Blind (MCB), and the 1902(r)(2) expansion COAs. Benefit service projections for the three extension years will be for Families, Disabled, and 1902(r)(2) expansion COAs; the MCB COA will be subsumed into the Disabled COA. A base will be determined for each, on an accrual date of service basis, which will be projected in the future on a yearly basis. The base amounts and subsequent annual target amounts will be subject to adjustment if inaccuracies are subsequently identified as a result of Commonwealth or Federal reviews and audits.

The benefit base will be Commonwealth Fiscal Year (SFY) 1994. The Commonwealth will report base period costs to the project officer by September 1, 1995. The Commonwealth may update the base period costs to account for claims with SFY94 dates of service processed after the initial base period data has been provided. Final base period costs will be reported to the project officer no later than September 1, 1996. The DSH base will be lower of actual expenditures or $594.5 million, the Commonwealth's estimate of its final FFY95 allotment. The total expenditure limit over the 8-year demonstration will be the sum of the annual expenditure targets of the two components.

1 Projected Expenditures for the Benefit Services

Families, Disabled, MCB, and 1902(r)(2) COA base year per capita costs for actual allowable benefit services, determined on an accrual date of service basis, will be calculated by dividing the SFY 1994 Medicaid benefit expenditures (less excluded expenses and DSH), for each COA, by SFY 1994 average monthly eligibles in the corresponding COA. All current Medicaid eligibles are included in the base year calculation except for the aged. Also included in calculating the service payment upperline will be those categorical eligible months as described in the agreement on counting conventions.

The Commonwealth shall estimate the 1994 baseline for the 1902(r)(2) eligibles, which should include disabled persons eligible as a result of expanding income from 104 percent of FPL to 133 percent, using the same methodology as in the MassHealth proposal since claims experience does not exist for this group. The baseline will be adjusted to reflect actual experience if expenditures for the 1902(r)(2) eligibles in the first year of the demonstration are more than 10 percent above or below the baseline.

Once the base year per capita costs for each category has been determined, it will be projected forward by the corresponding growth rate listed below. The annual expenditure target for Medicaid benefit expenditures in a given year will be the sum across COAs of: the product of the projected per capita cost for a COA for that year multiplied by the number of COA eligibles, including eligibles counted as categorical according to the counting conventions agreement, where the method for counting eligibles, including any factoring of the duration of eligibility, is consistent with the counting method used in the calculation of base year per capita costs and MassHealth capitation payments.

The specific growth rates for the per capita costs for each year of the first five years of the demonstration are listed below.

Federal	Growth Factor by Category of Assistance			
Fiscal Year	Families	Disabled	MCB	1902(r)(2)
1995	5.90%	3.46%	3.46%	2.30%
1996	7.71%	5.83%	5.83%	4.40%
1997	7.71%	5.83%	5.83%	4.80%
1998	7.71%	5.83%	5.83%	5.50%
1999	7.71%	5.83%	5.83%	5.30%
2000	7.71%	5.83%	5.83%	5.70%

Since the above rates are based on Federal fiscal years, weighting adjustments will need to be completed to align the FFY rates with the waiver years (WY). For example, using the 1902(r)(2) COA, if the first waiver year runs from January 1, 1996 through December 31, 1996 the following adjustment will be made:

FFY 1996: 4.40% times 75% = 3.30%
FFY 1997: 4.80% times 25% = 1.20%
WY 1996 rate 4.50%

The growth rate for waiver year 2000 will be the FFY 2000 rates.

For the three year extension period, the growth rates shall be as listed below. The growth rates are based on waiver years, which correspond to the state's fiscal year. The MCB COA from the first five years of the demonstration will be subsumed into the Disabled COA. For the 1902(r)(2) COA, the Disabled growth rate shall apply to disabled 1902(r)(2) eligibles, and the Families growth rate shall apply to the non-disable 1902(r)(2) eligibles.

State	Growth Factor by Category of Assistance			
Fiscal Year	Families	Disabled	1902(r)(2)-Non-disabled	1902(r)(2)-Disabled
2003	7.71%	10.00%	7.71%	10.00%
2004	7.71%	10.00%	7.71%	10.00%
2005	7.71%	10.00%	7.71%	10.00%

2 Projected Disproportionate Share (DSH) Expenditures

The projected yearly DSH expenditures for the demonstration will be calculated using a base year figure grown at a predetermined growth rate. The base for DSH will be the lower of the Commonwealth's total DSH expenditures for FFY 1995 or $594.500 million, which is the Commonwealth's current estimate of its final allotment for FFY 1995. The base amount will be grown over the first 5 years of the waiver at 6.79%, which is the expected average annual growth in national DSH expenditures over the life of the waiver. For the three year extension period, the projected yearly DSH expenditures shall be the lesser of actual expenditures or the DSH allotment established by law.

3 Total Expenditure Limit for Expenditures Included in the Upperline.

The total expenditure limit over the 8-year demonstration period will be the sum of the annual expenditure targets described above. Actual expenditures will be reported on the HCFA 64 forms that the Commonwealth must submit. The Commonwealth's expenditures must not exceed the budget neutrality test; that is, the Commonwealth's total expenditures for all eight years of the demonstration may not exceed the sum over the eight year demonstration period of actual allowable expenditures, calculated on an accrual date of service basis, of the following two components: a) yearly per capita expenditures for benefit services (less excluded services defined below, and DSH) and b) the yearly DSH expenditure limits. During the demonstration, claims for FFP will be made through the regular Medicaid reporting process, using the standard HCFA 64 forms. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. No new limit is placed on the FFP that the Commonwealth can claim for expenditures in program categories listed under section 4 below. If the demonstration is terminated prior to the 8-year period, the budget neutrality test will be based on the time period through the termination date. Extension of the waiver beyond a 8-year operational period will not affect enforcement of budget neutrality as described above.

4 Expenditures Excluded From Upperline Tests

Regular FMAP will continue for costs not subject to budget neutrality upperline tests. Those exclusions include:

- Expenditures made on behalf of enrollees age 65 years of age and above.

- All Long Term Care expenditures.

- Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for federal reimbursement. As part of the protocol the Commonwealth shall submit to CMS the methodology that will be used to determine whether expenditures incurred by other cities and towns meet the criteria to be excluded from the budget neutrality test. This methodology shall insure that such expenditures are not inappropriately disregarded in the calculation of the budget cap.

- Expenses incurred for services provided prior to the date of waiver implementation, that is, the date of service is prior to the waiver effective date, including payments made during the waiver period for prior period adjustments related to pre-waiver period service and claims activity. MassHealth expenditures will be tracked on an accrual basis.

- Allowable administrative expenditures.

5 Expenditure Review

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of an individual waiver year, the Commonwealth will calculate annual expenditure targets (using actual categorical eligibles, including eligibles counted as categorical eligibles according to the counting convention agreement) for the completed year for each of the two components (benefits, and DSH). The annual component targets will be summed to calculate a target annual spending limit. This amount should be compared with the actual claimed FFP for Medicaid. Using the below schedule as a guide, if the Commonwealth exceeds these targets they shall submit a corrective action plan to CMS for approval.

- Year 1 target spending limit	+8 percent
- Year 1 to 2 combined target spending limit	+6 percent
- Year 1 to 3 combined target spending limit	+4 percent
- Year 1 to 4 combined target spending limit	+2 percent
- Year 1 to 5 combined target spending limit	+0 percent
- Year 1 to 6 combined target spending limit	+3 percent
- Year 1 to 7 combined target spending limit	+1 percent
- Year 1 to 8 combined target spending limit	+0 percent

Should the corrective action plan result in limiting enrollment into MassHealth, entrance into programs providing health insurance for the neediest should be preserved as much as possible. The following ranking, in terms of declining order of importance, lists programs to be protected from entrance barriers: 1) the traditional Medicaid programs (HMO, PCCP, and FFS), 2) NSBP, 3) tax credits for "new employer-provided health insurance" under the IRP, 4) CommonHealth, 5) Medical Security Program, and 6) employee subsidy under the IRP. Should FFP be provided for tax credits for "continuing or improved employer-provided health insurance" this program should have the least degree of protection from discontinued entrance to the program.

Attachment B

Terms and Conditions for Access Standards, Quality Monitoring and Financial Monitoring of Managed Care Plans

Guidelines for Internal Quality Monitoring Programs

As part of the protocol, the Commonwealth must provide its overall quality assurance monitoring plan. This must include a discussion of all quality indicators it plans to study and the methodology for measuring such indicators.

Access Standards

Contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied and paramedical personnel for the provision of all covered services on an emergency basis, 24-hour-a-day, 7-day-a-week basis. At a minimum, unless the Commonwealth can demonstrate otherwise, this shall include:

! Primary Care Delivery Site:

(a) Distance/Time: No more than 30 miles or 30 minutes for all enrollees in a service area.

(b) Patient Load: A patient/primary care physician ratio to be determined by the Commonwealth and approved by the CMS project officer 30 days prior to implementation of the program.

(c) Appointment/Waiting Times: Usual and customary practice not to exceed 30 days from date of a patient's request for non-symptomatic office visits and 48 hours for urgent care.

(d) Documentation/Tracking requirements:

+ Documentation - Managed Care Plans (MCPs) must have a system in place to document appointment scheduling times. The Commonwealth must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the required beneficiary survey.

+ Tracking - MCPs must have a system in place to document the exchange of client information with the primary care provider if a school-based health center, not serving as the primary care provider, provides health care.

! Specialty Care and Emergency Care: Referral appointments to specialists, except for specialists providing mental health and substance abuse services, (e.g., specialty physician services, hospice care, home health care, and certain rehabilitation services,

etc.) shall not exceed 30 days for routine are or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts.

- Hospitals: Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater and for mental health and physical rehabilitative services where access is not to exceed 60 minutes. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the Commonwealth on the basis of community standards.

- General Dental Services:

  (a) Transport time will be the usual and customary, not to exceed one hour, except in rural areas where community standards and documentation will apply.

  (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care.

- General Optometry Services:

  (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation shall apply.

  (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care.

- Pharmacy Services:

  (a) Transport time will be the usual and customary, not to exceed one hour, except in rural areas where community access standards and documentation will apply.

- Lab and X-Ray Services:

  (a) Transport time will be the usual and customary, not to exceed one hour, except in rural areas where community access standards and documentation will apply.

  (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care.

- All other services not specified here shall meet the usual and customary standards for the community.

Definition of "Usual and Customary" - access that is equal to or greater than the currently existing practice in the fee-for-service system.

<u>Guidelines for Commonwealth Monitoring of MCPs</u>

- The Commonwealth will require, by contract, that MCPs meet certain Commonwealth-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR Part 434.

- The Commonwealth will monitor, on a periodic or continuous basis (but no less often than every 12 months), MCP adherence to these standards, through the following mechanisms: review of each plan's written QAP, review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes, and on-site monitoring of the implementation of the QAP standards.

- Recipient access to care will be monitored through the following Commonwealth activities: periodic comparison of the number and types of providers before and after the waiver, periodic surveys which contain questions concerning recipient access to services, measurement of waiting periods to obtain health care services, and measurement of referral rates to specialists.

Guidelines for MCP Monitoring of Providers

- MCPs will require, by contract, that providers meet specified standards as required by the Commonwealth contract.

- MCPs will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

Guidelines for Financial Monitoring of Providers

- The Commonwealth shall provide to CMS, upon request, copies of all financial statements filed by insurers with the Massachusetts Division of Insurance.

- The Commonwealth shall provide to CMS, upon request, copies of any Division of Insurance documents related to their monitoring of the financial stability of insurers and HMOs.

- The Commonwealth shall provide to CMS, upon request, copies of all audits conducted by the Commonwealth under the Federal Single Audit Act.

Attachment C

MassHealth
Outline for Operational Protocol

Massachusetts will be responsible for developing a detailed protocol describing the MassHealth demonstration. The protocol is a stand alone document that reflects the operating policies and administrative guidelines of the demonstration. The Massachusetts Division of Medical Assistance shall assure and monitor compliance with the protocol. Areas that should be addressed in the document include:

1. organizational and structural configuration of the demonstration arrangements
2. organization of managed care networks
3. payment mechanism
4. benefit packages
5. MassHealth eligibility process
6. marketing and outreach strategy
7. enrollment process
8. eligibility simplification
9. quality assurance and utilization review system
10. grievance and appeal policies
11. administrative and management system
12. encounter data
13. federally qualified health centers
14. family planning services
15. financial reporting
16. risk-sharing procedures
17. proposed provider-enrollee ratios, access standards, etc.